

TAB E

105TH CONGRESS }
1st Session

HOUSE OF REPRESENTATIVES

{ REPORT
105-149

BALANCED BUDGET ACT OF 1997

R E P O R T

OF THE

COMMITTEE ON THE BUDGET HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 2015

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SUB-
SECTIONS (b)(1) AND (c) OF SECTION 105 OF THE CONCURRENT
RESOLUTION ON THE BUDGET FOR FISCAL YEAR 1998

together with

ADDITIONAL AND MINORITY VIEWS



JUNE 24, 1997.—Committed to the Committee of the Whole House on
the State of the Union and ordered to be printed

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(b) CONFORMING AMENDMENTS.—(1) Section 1902(a)(47) of such Act (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: “and provide for making medical assistance for items and services described in subsection (a) of section 1920A available to children during a presumptive eligibility period in accordance with such section”.

(2) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) of such Act is amended by inserting before the period at the end the following: “or for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

TITLE IV—COMMITTEE ON COMMERCE—MEDICARE

SEC. 4000. AMENDMENTS TO SOCIAL SECURITY ACT AND REFERENCES TO OBRA; TABLE OF CONTENTS OF TITLE.

(a) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(b) REFERENCES TO OBRA.—In this title, the terms “OBRA-1986”, “OBRA-1987”, “OBRA-1989”, “OBRA-1990”, and “OBRA-1993” refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66), respectively.

(c) TABLE OF CONTENTS OF TITLE.—The table of contents of this title is as follows:

Sec. 4000. Amendments to Social Security Act and references to OBRA; table of contents of title.

Subtitle A—MedicarePlus Program

CHAPTER 1—MEDICAREPLUS PROGRAM

SUBCHAPTER A—MEDICAREPLUS PROGRAM

Sec. 4001. Establishment of MedicarePlus program.

“PART C—MEDICAREPLUS PROGRAM

“Sec. 1851. Eligibility, election, and enrollment.

“Sec. 1852. Benefits and beneficiary protections.

“Sec. 1853. Payments to MedicarePlus organizations.

“Sec. 1854. Premiums.

“Sec. 1855. Organizational and financial requirements for MedicarePlus organizations; provider-sponsored organizations.

“Sec. 1856. Establishment of standards.

“Sec. 1857. Contracts with MedicarePlus organizations.

“Sec. 1859. Definitions; miscellaneous provisions.

Sec. 4002. Transitional rules for current medicare HMO program.

Sec. 4003. Conforming changes in medigap program.

SUBCHAPTER B—SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

Sec. 4006. MedicarePlus MSA.

SUBCHAPTER C—GME, IME, AND DSH PAYMENTS FOR MANAGED CARE ENROLLEES

Sec. 4008. Graduate medical education and indirect medical education payments for managed care enrollees.

Sec. 4009. Disproportionate share hospital payments for managed care enrollees.

CHAPTER 2—INTEGRATED LONG-TERM CARE PROGRAMS

SUBCHAPTER A—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Sec. 4011. Reference to coverage of PACE under the medicare program.

Sec. 4012. Reference to establishment of PACE program as medicaid State option.

SUBCHAPTER B—SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (SHMOs)

Sec. 4015. Social health maintenance organizations (SHMOs).

SUBCHAPTER C—OTHER PROGRAMS

Sec. 4018. Orderly transition of municipal health service demonstration projects.

Sec. 4019. Extension of certain medicare community nursing organization demonstration projects.

CHAPTER 3—MEDICARE PAYMENT ADVISORY COMMISSION

Sec. 4021. Medicare Payment Advisory Commission.

CHAPTER 4—MEDIGAP PROTECTIONS

Sec. 4031. Medigap protections.

Sec. 4032. Medicare prepaid competitive pricing demonstration project.

Subtitle B—Prevention Initiatives

Sec. 4101. Screening mammography.

Sec. 4102. Screening pap smear and pelvic exams.

Sec. 4103. Prostate cancer screening tests.

Sec. 4104. Coverage of colorectal screening.

Sec. 4105. Diabetes screening tests.

Sec. 4106. Standardization of medicare coverage of bone mass measurements.

Sec. 4107. Vaccines outreach expansion.

Sec. 4108. Study on preventive benefits.

Subtitle C—Rural Initiatives

Sec. 4206. Informatics, telemedicine, and education demonstration project.

Subtitle D—Anti-Fraud and Abuse Provisions

Sec. 4301. Permanent exclusion for those convicted of 3 health care related crimes.

Sec. 4302. Authority to refuse to enter into medicare agreements with individuals or entities convicted of felonies.

Sec. 4303. Inclusion of toll-free number to report medicare waste, fraud, and abuse in explanation of benefits forms.

Sec. 4304. Liability of medicare carriers and fiscal intermediaries for claims submitted by excluded providers.

Sec. 4305. Exclusion of entity controlled by family member of a sanctioned individual.

Sec. 4306. Imposition of civil money penalties.

Sec. 4307. Disclosure of information and surety bonds.

Sec. 4308. Provision of certain identification numbers.

Sec. 4309. Advisory opinions regarding certain physician self-referral provisions.

Sec. 4310. Nondiscrimination in post-hospital referral to home health agencies.

Sec. 4311. Other fraud and abuse related provisions.

Subtitle E—Prospective Payment Systems

CHAPTER 2—PAYMENT UNDER PART B

SUBCHAPTER A—PAYMENT FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Sec. 4411. Elimination of formula-driven overpayments (FDO) for certain outpatient hospital services.

- Sec. 4412. Extension of reductions in payments for costs of hospital outpatient services.
- Sec. 4413. Prospective payment system for hospital outpatient department services.

SUBCHAPTER B—REHABILITATION SERVICES

- Sec. 4421. Rehabilitation agencies and services.
- Sec. 4422. Comprehensive outpatient rehabilitation facilities (corf).

SUBCHAPTER C—AMBULANCE SERVICES

- Sec. 4431. Payments for ambulance services.
- Sec. 4432. Demonstration of coverage of ambulance services under medicare through contracts with units of local government.

CHAPTER 3—PAYMENT UNDER PARTS A AND B

- Sec. 4441. Prospective payment for home health services.

Subtitle G—Provisions Relating to Part B Only

CHAPTER 1—PHYSICIANS' SERVICES

- Sec. 4601. Establishment of single conversion factor for 1998.
- Sec. 4602. Establishing update to conversion factor to match spending under sustainable growth rate.
- Sec. 4603. Replacement of volume performance standard with sustainable growth rate.
- Sec. 4604. Payment rules for anesthesia services.
- Sec. 4605. Implementation of resource-based physician practice expense.
- Sec. 4606. Dissemination of information on high per admission relative values for in-hospital physicians' services.
- Sec. 4607. No X-ray required for chiropractic services.
- Sec. 4608. Temporary coverage restoration for portable electrocardiogram transportation.

CHAPTER 2—OTHER PAYMENT PROVISIONS

- Sec. 4611. Payments for durable medical equipment.
- Sec. 4612. Oxygen and oxygen equipment.
- Sec. 4613. Reduction in updates to payment amounts for clinical diagnostic laboratory tests.
- Sec. 4614. Simplification in administration of laboratory services benefit.
- Sec. 4615. Updates for ambulatory surgical services.
- Sec. 4616. Reimbursement for drugs and biologicals.
- Sec. 4617. Coverage of oral anti-nausea drugs under chemotherapeutic regimen.
- Sec. 4618. Rural health clinic services.
- Sec. 4619. Increased medicare reimbursement for nurse practitioners and clinical nurse specialists.
- Sec. 4620. Increased medicare reimbursement for physician assistants.
- Sec. 4621. Renal dialysis-related services.
- Sec. 4622. Payment for cochlear implants as customized durable medical equipment.

CHAPTER 3—PART B PREMIUM

- Sec. 4631. Part B premium.

Subtitle H—Provisions Relating to Parts A and B

CHAPTER 1—PROVISIONS RELATING TO MEDICARE SECONDARY PAYER

- Sec. 4701. Permanent extension and revision of certain secondary payer provisions.
- Sec. 4702. Clarification of time and filing limitations.
- Sec. 4703. Permitting recovery against third party administrators.

CHAPTER 2—HOME HEALTH SERVICES

- Sec. 4711. Recapturing savings resulting from temporary freeze on payment increases for home health services.
- Sec. 4712. Interim payments for home health services.
- Sec. 4713. Clarification of part-time or intermittent nursing care.
- Sec. 4714. Study of definition of homebound.
- Sec. 4715. Payment based on location where home health service is furnished.

- Sec. 4716. Normative standards for home health claims denials,
- Sec. 4717. No home health benefits based solely on drawing blood.
- Sec. 4718. Making part B primary payor for certain home health services.

CHAPTER 3—BABY BOOM GENERATION MEDICARE COMMISSION

- Sec. 4721. Bipartisan Commission on the Effect of the Baby Boom Generation on the Medicare Program.

CHAPTER 4—PROVISIONS RELATING TO DIRECT GRADUATE MEDICAL EDUCATION

- Sec. 4731. Limitation on payment based on number of residents and implementation of rolling average FTE count.
- Sec. 4732. Phased-in limitation on hospital overhead and supervisory physician component of direct medical education costs.
- Sec. 4733. Permitting payment to non-hospital providers.
- Sec. 4734. Incentive payments under plans for voluntary reduction in number of residents.
- Sec. 4735. Demonstration project on use of consortia.
- Sec. 4736. Recommendations on long-term payment policies regarding financing teaching hospitals and graduate medical education.
- Sec. 4737. Medicare special reimbursement rule for certain combined residency programs.

CHAPTER 5—OTHER PROVISIONS

- Sec. 4741. Centers of excellence.
- Sec. 4742. Medicare part B special enrollment period and waiver of part B late enrollment penalty and medigap special open enrollment period for certain military retirees and dependents.
- Sec. 4743. Competitive bidding for certain items and services.

Subtitle I—Medical Liability Reform

CHAPTER 1—GENERAL PROVISIONS

- Sec. 4801. Federal reform of health care liability actions.
- Sec. 4802. Definitions.
- Sec. 4803. Effective date.

CHAPTER 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

- Sec. 4811. Statute of limitations.
- Sec. 4812. Calculation and payment of damages.
- Sec. 4813. Alternative dispute resolution.

Subtitle A—MedicarePlus Program

CHAPTER 1—MEDICAREPLUS PROGRAM

Subchapter A—MedicarePlus Program

SEC. 4001. ESTABLISHMENT OF MEDICAREPLUS PROGRAM.

(a) IN GENERAL.—Title XVIII is amended by redesignating part C as part D and by inserting after part B the following new part:

“PART C—MEDICAREPLUS PROGRAM

“ELIGIBILITY, ELECTION, AND ENROLLMENT

“SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICAREPLUS PLANS.—

“(1) IN GENERAL.—Subject to the provisions of this section, each MedicarePlus eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

“(A) through the medicare fee-for-service program under parts A and B, or

SEC. 4615. UPDATES FOR AMBULATORY SURGICAL SERVICES.

Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended by striking all that follows “shall be increased” and inserting the following: “as follows:

“(i) For fiscal years 1996 and 1997, by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

“(ii) For each of fiscal years 1998 through 2002 by such percentage increase minus 2.0 percentage points.

“(iii) For each succeeding fiscal year by such percentage increase.”.

SEC. 4616. REIMBURSEMENT FOR DRUGS AND BIOLOGICALS.

(a) IN GENERAL.—Section 1842 (42 U.S.C. 1395u) is amended by inserting after subsection (n) the following new subsection:

“(o) If a physician’s, supplier’s, or any other person’s bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to 95 percent of the average wholesale price.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to drugs and biologicals furnished on or after January 1, 1998.

SEC. 4617. COVERAGE OF ORAL ANTI-NAUSEA DRUGS UNDER CHEMOTHERAPEUTIC REGIMEN.

(a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended, is amended by inserting after subparagraph (S) the following new subparagraph:

“(T) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or as prescribed by a physician)—

“(i) for use immediately before, immediately after, or at the time of the administration of the anticancer chemotherapeutic agent; and

“(ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.”.

(b) PAYMENT LEVELS.—Section 1834 (42 U.S.C. 1395m), as amended by sections 4421(a)(2) and 4431(b)(2), is amended by adding at the end the following new subsection:

“(m) SPECIAL RULES FOR PAYMENT FOR ORAL ANTI-NAUSEA DRUGS.—

“(1) LIMITATION ON PER DOSE PAYMENT BASIS.—Subject to paragraph (2), the per dose payment basis under this part for oral anti-nausea drugs (as defined in paragraph (3)) administered during a year shall not exceed 90 percent of the average per dose payment basis for the equivalent intravenous antiemetics administered during the year, as computed based on the payment basis applied during 1996.

“(2) AGGREGATE LIMIT.—The Secretary shall make such adjustment in the coverage of, or payment basis for, oral anti-nausea drugs so that coverage of such drugs under this part

SEC. 10616. REIMBURSEMENT FOR DRUGS AND BIOLOGICALS.

(a) IN GENERAL.—Section 1842 (42 U.S.C. 1395u) is amended by inserting after subsection (n) the following new subsection:

“(o) If a physician’s, supplier’s, or any other person’s bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to 95 percent of the average wholesale price.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to drugs and biologicals furnished on or after January 1, 1998.

SEC. 10617. COVERAGE OF ORAL ANTI-NAUSEA DRUGS UNDER CHEMOTHERAPEUTIC REGIMEN.

(a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended, is further amended—

(1) by striking “and” at the end of subparagraph (R); and

(2) by inserting after subparagraph (S) the following new subparagraph:

“(T) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or under the supervision of a physician)—

“(i) for use immediately before, immediately after, or at the time of the administration of the anticancer chemotherapeutic agent; and

“(ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.”.

(b) PAYMENT LEVELS.—Section 1834 (42 U.S.C. 1395m), as amended by sections 10421(a)(2) and 10431(b)(2), is amended by adding at the end the following new subsection:

“(m) SPECIAL RULES FOR PAYMENT FOR ORAL ANTI-NAUSEA DRUGS.—

“(1) LIMITATION ON PER DOSE PAYMENT BASIS.—Subject to paragraph (2), the per dose payment basis under this part for oral anti-nausea drugs (as defined in paragraph (3)) administered during a year shall not exceed 90 percent of the average per dose payment basis for the equivalent intravenous antiemetics administered during the year, as computed based on the payment basis applied during 1996.

“(2) AGGREGATE LIMIT.—The Secretary shall make such adjustment in the coverage of, or payment basis for, oral anti-nausea drugs so that coverage of such drugs under this part does not result in any increase in aggregate payments per capita under this part above the levels of such payments per capita that would otherwise have been made if there were no coverage for such drugs under this part.

“(3) ORAL ANTI-NAUSEA DRUGS DEFINED.—For purposes of this subsection, the term ‘oral anti-nausea drugs’ means drugs for which coverage is provided under this part pursuant to section 1861(s)(2)(P).”.

The provision would require the inclusion of a laboratory representative on carrier advisory committees. The representative would be selected by the committee from nominations submitted by national and local organizations representing independent clinical labs.

Section 4615. Updates for ambulatory surgical services

Current Law. Medicare pays for ambulatory surgical center (ASC) services on the basis of prospectively determined rates. These rates are updated annually by the CPI-U. OBRA 93 eliminated updates for ASCs for FY 1994 and FY 1995.

Explanation of Provision. The provision would set the updates for FY 1996 and FY 1997 at the percentage increase in the CPI-U. For FY 1998 through FY 2002, the update increase would be the increase in the CPI-U minus 2.0 percentage points. For and succeeding fiscal years, the update increase would be the increase in the CPI-U.

Section 4616. Reimbursement for drugs and biologicals

Current Law. Payment for drugs is based on the lower of the estimated acquisition cost or the national average wholesale price. Payment may also be made as part of a reasonable cost or prospective payment.

Explanation of Provision. The provision would specify that in any case where payment is not made on a cost or prospective payment basis, the payment would equal 95 percent of the average wholesale price, as specified by the Secretary.

Section 4617. Coverage of oral anti-nausea drugs under chemotherapeutic regimen

Current Law. Medicare provides coverage for certain oral cancer drugs. The Administration has specified that Medicare will pay for self-administrable oral or rectal versions of self-administered anti-emetic drugs when they are needed for the administration and absorption of primary Medicare covered oral anti-cancer chemotherapeutic agents when a high likelihood of vomiting exists.

Explanation of Provision. The provision would provide coverage, under specified conditions, for an oral drug used as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen. It would have to be administered by or under the supervision of a physician for use immediately before, at the time of or immediately after the administration of the chemotherapeutic agent and used as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.

The provision would establish a per dose payment limit equal to 90 percent of the average per dose payment basis for the equivalent intravenous anti-emetics administered during the year, as computed based on the payment basis applied in 1996. The Secretary would be required to make adjustments in the coverage of, or payment, for the anti-nausea drugs so that an increase in aggregate payments per capita does not result.

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provision is intended to promote efficiency, increase uniformity, and reduce administrative burdens in claims administration and billing procedures.

Effective Date. The provision is effective upon enactment.

Section 10615. Updates for ambulatory surgical services

Current Law. Medicare pays for ambulatory surgical center (ASC) services on the basis of prospectively determined rates. These rates are updated annually by the CPI-U. OBRA 93 eliminated updates for ASCs for FY1994 and FY1995.

Explanation of Provision. The provision would set the updates for FY 1998 through FY2002 at the increase in the CPI-U minus 2.0 percentage points.

Reason for change. This provision would contribute to slowing unsustainable growth in Part B expenditures.

Effective date. This provision is effective for services delivered on or after October 1, 1997.

Section 10616. Reimbursement for drugs and biologicals

Current Law. Payment for drugs is based on the lower of the estimated acquisition cost or the national average wholesale price. Payment may also be made as part of a reasonable cost or prospective payment.

Explanation of Provision. The provision would specify that in any case where payment is not made on a cost or prospective payment basis, the payment shall be equal to 95 percent of the average wholesale price for the drug or biological involved.

Reason for Change. The Inspector General for the Department of Health and Human Services has found evidence that over the past several years Medicare has paid significantly more for drugs and biologicals than physicians and pharmacists pay to acquire such pharmaceuticals. For example, the Office of Inspector General reports that Medicare reimbursement for the top 10 oncology drugs ranges from 20 percent to nearly 1000 percent per dosage more than acquisition costs. The Committee intends that the Secretary, in determining the average wholesale price, should take into consideration commercially available information including such information as may be published or reported in various commercial reporting services. The Committee will monitor AWP's to ensure that this provision does not simply result in a 5% increase in AWP's.

Effective Date. The provision is effective January 1, 1998.

Section 10617. Coverage of oral anti-nausea drugs under chemotherapeutic regimen

Current Law. Medicare provides coverage for certain oral cancer drugs. The Administration has specified that Medicare will pay for anti-emetic drugs when they are needed for the administration and absorption of primary Medicare covered oral anticancer chemotherapeutic agents when a high likelihood of vomiting exists.

Explanation of Provision. The provision would provide coverage, under specified conditions, for a self-administered oral drug used as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen. It would have to be administered by or under the supervision of a physician for use immediately before,

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Durable medical equipment, orthotics and prosthetics, and parenteral and enteral nutrition

Payment rates for durable medical equipment, and orthotics and prosthetics would be frozen at 1997 levels through 2002. Starting in 2003, payments would be updated by the CPI-U. Updated for parenteral and enteral nutrition (PEN) would be reduced to their 1995 level for fiscal years 1998–2002. These provisions would save \$0.8 billion over the 1998–2002 period.

Oxygen and oxygen equipment

Payments for oxygen and oxygen equipment would be cut by 20 percent in 1998 and frozen through 2002. This provision would result in \$1.6 billion in savings between 1998 and 2002.

Laboratory updates

Under the proposal, the payment update for laboratory services would be frozen through 2002. This provision would also reduce the laboratory payment limit from 76 percent of the median fee schedule amount to 72 percent of this amount. These changes would save Medicare \$2.5 billion cumulatively through 2002.

Laboratory administrative simplification

The proposal would standardize the claims processing system for most laboratory services covered under Part B. The Secretary would select five regional carriers to process claims for all laboratory services, except those furnished in an independent physician's office. Claims would be processed by the regional carrier covering the area where the lab specimen was collected.

The Secretary would also be required to use a negotiated rule-making process to adopt uniform coverage, payment and administration policies for laboratory tests. The proposal would allow regional carriers to implement interim coverage policies in situations where no uniform national policy existed and carriers would be required to respond to excessive or fraudulent spending. The Secretary would review these interim policies every two years and decide whether to incorporate them into national policy. She would also periodically review proposals to change the uniform national policies.

Because there are no data indicating whether employing regional carriers and instituting uniform national policies would result in program costs or savings, CBO estimates that this provision would have no net budgetary effect.

Pharmaceutical payments

This provision would change the payment basis for drugs and biologicals covered under Part B. Currently, Medicare pays the average wholesale price (AWP) for drugs, which is a price reported by the manufacturer. Under the proposal, Medicare would pay 95 percent of the AWP for all drugs and biologicals covered under Part B, except those paid on a cost or prospective basis. Because the provision has no mechanism for controlling inflation in drug prices, CBO assumes that manufacturers would raise the AWP for their products to compensate for the payment cuts. Nevertheless, the provision would save \$0.4 billion over five years.